DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165326	A. BUILDING ______ B. WING ______	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMFIELD CARE CENTER	800 NORTH DAVIS STREET BLOOMFIELD, IA 52537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 03/01/2024 The following deficiencies resulted from the facility's Annual Recertification Survey conducted on January 29, 2024 to February 01, 2024. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Newman	Administrator	02/15/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to address the resident's Care Plan for the medical diagnosis of diabetes, and address the resident's diuretic medication for 2 of 5 residents reviewed for unnecessary medications Resident #5, #9). The facility reported a census of 41 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) Assessment dated 11/20/23 revealed Resident #9 scored a 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam, which indicated cognition moderately impaired. The MDS revealed a diagnosis of Diabetes Mellitus (DM) and the resident received insulin 7 out of 7 days.

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F 656	Continued From page 2 The Care Plan lacked a focus area and interventions for the diagnosis of DM. The Electronic Medical Record (EMR) revealed the following diagnosis: a. Type 2 diabetes mellitus with diabetic chronic kidney disease b. Type 2 diabetes mellitus with diabetic neuropathy, unspecified The Physician Orders revealed the following orders: a. ordered 5/16/23- Levemir flextouch subcutaneous solution pen-injector 100 unit/ml (milliliter)- inject 5 unit subcutaneously at bedtime b. ordered 8/23/22- Novolog pen fill solution cartridge 100 unit/ml- inject 16 unit subcutaneously three times a day. Give with meals/hold if <100 c. ordered 6/17/21- check blood glucose level four times a day 2. The Quarterly MDS assessment dated 12/19/23 revealed Resident #5 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed diagnoses of heart failure and coronary artery disease. The MDS documented the resident received a diuretic. The Care Plan lacked documentation for a focus area or interventions for a diuretic. The EMR revealed the following diagnoses: a. chronic diastolic (congestive) heart failure The Physician Orders: a. ordered 9/8/23 - Lasix oral tablet 20 mg (Furosemide)- give 20 mg by mouth one time a day	F 656		

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F 656 Continued From page 3 F 656

During an interview on 2/1/24 at 11:07 AM, the MDS Coordinator queried if a resident diabetic and on insulin if she expected it to be addressed on the care plan and she stated yes, it would be. The MDS Coordinator confirmed she didn't see it addressed on Resident #9 care plan. The MDS Coordinator queried if they addressed diuretics on the care plan and she stated yes, they should be on the care plan. The MDS Coordinator asked if Resident #5 diuretic addressed on the care plan and she stated no, and it should be on there.

During an interview on 2/1/24 at 11:52 AM, the Director of Nursing (DON) queried on the expectations for diuretics being addressed on the care plan and she stated well, they don't need to be on there. The DON asked her expectation for diabetes to be addressed on the care plan, and she stated she expected if care needed done around the area. The DON asked if Resident #9 need care around the area and she stated yes, they needed to watch for hyperglycemia and hypoglycemia.

During an interview on 2/1/24 at 12:38 PM, the DON stated the facility didn't have a policy for care plans. She stated that care plans were something they learned in school, and it was a standard of care.

F 658 SS=D Services Provided Meet Professional Standards F 658
CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.

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F 658	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure insulin held per physician ordered parameters. The facility also failed to document if insulin, and blood glucose checks were completed for 1 of 5 residents reviewed for unnecessary medications (Resident #9). The facility reported a census of 41 residents. Findings include: The Quarterly Minimum Data Set (MDS) Assessment dated 11/20/23 revealed Resident #9 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS documented a diagnosis of Diabetes Mellitus (DM), and the resident received insulin 7 out of 7 days. The Care Plan lacked a focus area, and interventions for the diagnosis of DM. The Electronic Medical Record (EMR) revealed the following diagnosis: a. Type 2 diabetes mellitus with diabetic chronic kidney disease b. Type 2 diabetes mellitus with diabetic neuropathy, unspecified The Physician Orders revealed the following orders: a. ordered 5/16/23- Levemir flextouch subcutaneous solution pen-injector 100 unit/ml (milliliter)- inject 5 unit subcutaneously at bedtime b. ordered 8/23/22- Novolog pen fill solution cartridge 100 unit/ml- inject 16 unit subcutaneously three times a day. Give with	F 658		

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F 658	Continued From page 5 meals/hold if <100 c. ordered 6/17/21- check blood glucose level four times a day Review of the Blood Glucose/Insulin Administration Record dated December 2023 revealed Novolog 16 units administered on the following date when the blood sugar level outside of parameter; a. 12/4/23 at lunch time the blood glucose level revealed 98 mg/dl (milliliters in deciliter) Review of the Blood Glucose/Insulin Administration Record dated December 2023 revealed Levemir 5 units administration on the following dates left blank; a. 12/6/23 at bedtime b. 12/15/23 at bedtime c. 12/29/23 at bedtime Review of the Blood Glucose/Insulin Administration Record record dated December 2023 revealed the following dates the blood glucose level left blank; a. 12/6/23 at bedtime b. 12/15/23 at bedtime Review of the Blood Glucose/Insulin Administration Record dated January 2024 revealed Novolog 16 units administered on the following dates when the blood sugar level outside of parameter; a. 1/4/24 at supper the blood glucose level revealed 95 b. 1/7/24 at supper the blood glucose level	F 658		

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F 658	Continued From page 6 revealed 95 Review of the Blood Glucose/Insulin Administration Record record dated January 2024 revealed the following dates the Novolog 16 units administration left blank; a. 1/13/24 at supper b. 1/14/24 at supper c. 1/18/24 at supper d. 1/20/24 at supper e. 1/21/24 at supper Review of the Blood Glucose/Insulin Administration Record record dated January 2024 revealed the following dates the blood glucose level left blank; a. 1/21/24 at supper During an interview on 1/31/24 at 4:10 PM, Staff A, Licensed Practical Nurse (LPN) queried if Resident #9 insulin order had parameters, and she stated no, usually they don't have parameters. Staff A informed the order revealed a parameter of 100 to hold and she looked up the medication, and stated yes, the order documented the parameters and she stated she didn't know when the parameters were ordered, and usually when the resident's blood sugars were low they called the provider. She stated if she believed she would of checked the blood sugar before she gave the insulin when the resident's reading read low. Staff A asked what the blank areas on the Blood Glucose/Insulin Administration Record, and she stated it meant they held the medication. Staff A asked if the medication held, would they document why in the progress note and she stated yes. Staff A	F 658		

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F 658	Continued From page 7 confirmed if the medication not documented as given, it revealed the medication red on the EMR. During an interview 2/1/24 at 8:26 AM, Director of Nursing (DON) stated she spoke to the nurses who didn't document the insulin administration, and the DON stated the nurses said they remembered giving the insulin to Resident #9. The DON stated she expected nurses to follow the orders as written. The DON asked if the EMR indicated if a medication given or not and she said it would for their shift but didn't show the next shift if the medication didn't get administered unless they went back and looked. The DON stated she expected staff to be checking to make sure the medication was administered and this was something they worked on. During an interview on 2/1/24 at 12:52 PM, the Corporate Nurse Consultant reported the facility didn't have a policy for medication administration. She stated they followed standards of care and they followed the 5 rights of medication administration liked you learned in school. The Corporate Policy Manual: Personnel/Human Resources, Licensed Nursing Orientation Checklist revised on 5/2002 on the following information for medication: a. Medication Administration Record (MARS), Treatment Administration Records (TARS) b. medication errors c. Medication administration standards of practice (Intramuscular, subcutaneously, eye drops, inhalers, gastric tube)	F 658		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		

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F 760	Continued From page 8 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident only received their own medications, and that the resident received the correct physician ordered dosage of their medication for 1 of 10 resident reviewed for medication administration (Resident #5). The facility reported a census of 41 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment dated 12/19/23 revealed Resident #5 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS documented diagnoses of depression and anxiety disorder. The MDS revealed the resident took an antidepressant and antianxiety medication. The Care Plan revealed a focus area for antidepressant medication to treat depression and anxiety. The interventions revealed administration of antidepressant medications as ordered by the physician and monitored/documented side effects and effectiveness with all concerns reported. The Electronic Medical Record (EMAR) revealed the following diagnoses: a. depression, unspecified b. anxiety disorder, unspecified The Physician Orders for Resident #5 revealed the following information: c. ordered on 9/7/23 and discontinued on 9/27/23:	F 760		

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F 760	Continued From page 9 Paxil (Paroxetine HCl (hydrochloride)) oral tablet 20 mg (milligrams)- give 20 mg by mouth one time a day d. ordered on 9/27/23: Paroxetine HCl oral tablet 30 mg- give 30 mg by mouth one time a day The Incident Report- Medication Report effective 11/26/23 at 6:59 AM revealed the following information: a. Medication Order- include medication name, dose, route, and time administered: medication wrong dose given 11/15/23, 11/16/23, 11/17/23, 11/18/23, 11/19/23, 11/20/23, 11/21/23, 11/22/23, 11/24/23, and 11/25/23. Order read Paxil order tablet 20 mg one time a day every day. b. Description of medication incident: Paxil 30 mg tablets were given orally once a day for the last 10 days c. Assessment of resident including vital signs: resident alert and oriented to person, place, time, and situation, denied pain, vitals signs within normal limits (WNL) blood pressure 117/64, pulse, 60, respirations 16 and regular, pulse oximetry saturation 97% on room air, temperature 97.1. The resident stated she been more sleepy recently. d. Physician notified (include date and time): [redacted name] call on 11/26/23 at 7:15 am e. responsible party notification (include date and time): emergency contact #1 and the Power of Attorney (POA) notified on 11/26/23 at 7:15 am The Incident Report- Medication Report effective date 1/28/24 at 8:46 PM revealed the following information: a. Medication Order- include medication name, dose, route and time to be administered: Resident given medication not prescribed to her. Seoul 300 mg, Trazadone 150 mg, Promethazine	F 760		

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25 mg, along with prescribed medication for her melatonin 6 mg and acetaminophen 650 mg.
b. Description of medication incident: environment loud, several things going on in surrounding area. Prepared medication and took it to resident's room. The resident took the medication and discussed pain and needed muscle rub with nurse.
c. Assessment of resident including vital signs: 90/52 blood pressure, temperature- 97.6, pulse 68, respirations 16, pulse oximetry saturation 92%
d. Physician notification (include date and time): [redacted name] on 1/28/24 at 8:30 PM
e. responsible party notification: son on 1/28/24 at 8:35 PM

The Review of Resident #23 Physician Orders revealed the following medication orders:
a. Promethazine HCl oral tablet- give 25 mg by mouth one time a day
b. Quetiapine Fumarate (Seroquel) oral tablet- give 300 mg by mouth one time a day
c. Trazadone HCl oral tablet- give 150 mg by mouth one time a day

The Review of Resident #5 Physician Orders revealed the resident not prescribed Promethazine, Quetiapine, and Trazadone.

During an interview on 1/29/24 at 11:42 AM, Resident #5 stated she received someone else medication. She stated she can't hardly sit up now. She stated she got a good night's sleep out of it. Resident sat on the side of her bed and ate lunch independently during the interview.

During an interview on 2/1/24 at 11:52 AM, the Director of Nursing (DON) stated she spoke to

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F 760	Continued From page 11 the nurse after it happened and the nurse stated she made mistake and got in a hurry. The DON stated she reviewed with staff the 5 rights of medication and stated she was a stickler on instructing the nurses to pop the medications, and save it and not to click off the medication until they gave the medication to the resident. The DON stated she instructed the nurse to double check the resident and if in doubt stop, and check what they were doing. During an interview on 2/1/24 at 12:52 PM, the Corporate Nurse Consultant stated the facility didn't have a policy for medication administration. She stated they followed standards of care and they followed the 5 rights of medication administration liked you learned in school. During an interview on 2/1/24 at 1:37 PM, Staff B, Registered Nurse (RN) queried about the medication incident on 1/28/24 and she stated she prepared the medication and took them down to Resident #5, and talked to the resident while she administered the medications and then went back to her medication care, then she realized she given the wrong medications to Resident #5. Staff B stated she gave Resident #23 medications to Resident #5. Staff B stated Resident #23 received her correct medications later in the evening. Staff B stated the DON gave her education after the incident. Staff B asked the expectation of medication administration and she stated to follow the 5 rights to medication administration. Staff B queried how Resident #5 acted after she received the wrong medications and she stated Resident #5 slept heavily, but easily woke up, displayed slurred speech, and used her call light when needed and told the staff her needs. Staff B asked if Resident #5 looked at	F 760		

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F 760	Continued From page 12 the medications in her cup prior to taking them and Staff B stated no, she takes the medications and at that time they talked about a muscle rub. During an interview on 2/1/24 at 1:47 PM, DON stated Resident #5 received Resident #23 medication. The DON asked her expectation on staff following the rights to medication administration and she stated she expected them to follow them. During an interview on 2/1/24 at 2:07 PM, the Provider stated she spoke to Resident #5 about the incident when she received another resident's medication and Resident #5 didn't state any concerns. The Provider queried on the expectation for staff to follow the physician orders and she stated for staff to check the name, date of birth, right time, right dose, and follow the physician orders as ordered. The Corporate Policy Manual: Personnel/Human Resources, Licensed Nursing Orientation Checklist revised on 5/2002 on the following information for medication: a. Medication Administration Record (MAR), Treatment Administration Records (TARs) b. Medication errors c. Medication administration standards of practice (Intramuscular, subcutaneously, eye drops, inhalers, gastric tube)	F 760		

Bloomfield Care Center, Provider #165326, Survey completed on 02/01/2024

Date Submitted: 02/23/2024

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

FOOO Correction Date: 03/01/2024

For the required Plan of Correction, the facility submits the following:

F656 Development/Implement Comprehensive Care Plan
The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs identified in the comprehensive assessment.

1. All residents Care Plans will be inclusive of each resident's diagnosis as they pertain to care, medications and treatments.
2. Professional Nursing Staff will be educated on 2/27/2024 regarding the importance of reporting any change of a resident's condition to their Charge Nurse. The Charge Nurses will be educated in providing all changes to the attention of the MDS Coordinator to ensure Care Plans will be updated if necessary.
3. The MDS Care Coordinator is receiving in depth individual training from the Corporate Utilization Review Specialist, with weekly audit reviews.
4. The MDS Care Coordinator or designee will be responsible for updating Care Plans on an ongoing basis, and quarterly with MDS reviews, updates or new diagnosis. Audits will be conducted by the Director of Nursing or designee as a part of our ongoing Quality Assurance process and the frequency of subsequent audits will be based on outcomes and recommendation of the Quality Assurance team.

F658 Required Nursing Services for Residents
The resident shall receive, and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set for in these rules.

1. Resident #9 provider was contacted on 2/01/2024, and an order was received to remove the parameter on the insulin.
2. All Insulin orders with parameters were reviewed by the primary provider on 2/06/2024 to ensure parameters were necessary.
3. Education provided to Nurses on 2/01/2024 regarding signing off Medication Administration.

4. Education will be provided to staff on 2/27/2024 including review of the CMS Pathway for Medication Administration and Medication Administration -Key Points to Remember Potter & Perry 9th Edition.
5. A Root Cause Analysis will be reviewed with the Medical Director on 2/26/2024 regarding receiving, communicating, and implementing Physician Orders.
6. The Director of Nursing or designee will perform audits weekly for three months to ensure Medication Administration documentation is signed properly. These audits will be reviewed as a part of our ongoing Quality Assurance process and subsequent audit frequencies will be based on outcomes and the recommendations of the Quality Assurance team.

Drugs, storage, and handling

1. On 2/01/2024 Resident # 5 Paxil order was verified with the Pharmacy for accuracy.
2. On 2/27/2024 education will be provided to Nurses and Medication Aides on the five rights of Medication Administration and how to correctly prepare to administer medication. Charting guidance will be provided at that time.
3. Regular Audits will be required on all new admissions to verify accuracy of Point Click Care orders. These orders will be compared to discharge orders. These audits will be reviewed as a part of our ongoing Quality Assurance process and subsequent audit frequencies will be based on outcomes and the recommendations of the Quality Assurance team.
4. The Director of Nursing or designee will supervise Nurses and Medication Aides monthly for one quarter to ensure proper medication administration.

F760 Drugs, storage, and handling
Drug Administration

1. Audits will be performed on all admission/re-admission orders for accuracy. Audits will be performed for the first quarter.
2. On 2/27/2024 education will be provided to Nurses and Medication Aides on the five rights of Medication Administration for administration of medications.
3. The Director of Nursing or designee will audit medication administration. These audits will be reviewed as a part of our ongoing Quality Assurance process and subsequent audit frequencies will be based on outcomes and the recommendations of the Quality Assurance team.